



HEARTS Respite

A Program of United Cerebral Palsy of Greater Birmingham

Application for Fiscal Year 2011-2012 (August 2011 through July 2012)

Dear Applicant for Respite Services,

Enclosed is an application for respite support through the **HEARTS Respite Program** of United Cerebral Palsy of Greater Birmingham. Respite care services are temporary, short-term breaks for caregivers of children and youth with disabilities. **Any funding support we provide cannot be used for routine child care.** HEARTS Respite serves only families of children under the age of 19 with a disability.

This year, we have only a small amount of funding from the Children's Trust Fund of Alabama to support this program. We can provide respite through a voucher system on a **QUARTERLY** basis (rather than a monthly basis). Families will choose, train and pay their own caregivers, then submit a voucher for reimbursement. This year, we will be able to reimburse up to \$50 per QUARTER for 70 families. In order to participate, we need for families to re-apply so that we can select the first 70 families who send in their application.

Attached is the application that needs to be completed and returned to me. **If you participated last year**, then all you need to do on the form is confirm that your information is still correct by checking the boxes on each line of the application. If anything has changed, then provide the new information on the line provided. **If you are a new applicant**, then you will need to complete the entire application.

Once I have received your completed application, I will let you know if you have been approved and how you can access respite support. Please remember that the HEARTS Respite Program serves only families who have children **under the age of 19 with a disability**. If you want to apply for respite services for more than one child, there is additional space on the application for this purpose.

Thank you for your interest and I will look forward to hearing back from you.

Sincerely,

A handwritten signature in black ink that reads "Jeri B. Jackson".

Jeri B. Jackson, Program Coordinator
HEARTS Respite of United Cerebral Palsy of Greater Birmingham
1317 Overland Drive, Birmingham, AL 35216
Phone: 205-823-9226; FAX 205-979-6134
Email: JBH50@aol.com

**HEARTS RESPITE
APPLICATION FORM FOR 2011-2012**

Today's Date: _____

Parent/Guardian Name: _____

Parent/Guardian Date of Birth: _____ Age: _____

**Check below if
your information
from last year
has not changed**



- **RETURNING FAMILIES**, please check the boxes below if your information is still the same as last year. If there are changes, please write them on the line.
- **NEW FAMILIES**, please complete the entire application by filling in the spaces below.

Email address: _____

Mailing Address: _____

City: _____ AL Zip: _____ County: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Parent/Guardian Sex:

- Female
- Male

Parent/Guardian Ethnicity:

- NOT of Hispanic, Latino, or Spanish origins
- Hispanic, Latino or Spanish origins

Parent/Guardian Race:

- White
- Black/African-American
- Asian
- American Indian (Native American) or Alaska Native
- Native Hawaiian, other Pacific Islander
- Other (please specify): _____

IF YOU ARE APPLYING FOR MORE THAN ONE CHILD, YOU MUST COMPLETE A SEPARATE SECTION FOR EACH CHILD

<input type="checkbox"/> Child's Name: _____		
<input type="checkbox"/> D.O.B. _____ Age: _____ (Must be under 19 to qualify)		
<input type="checkbox"/> Child's Diagnosis: _____ If you have not already sent in proof of your child's diagnosis or developmental delay, you MUST do so. This can be records from a medical facility or another service agency.		
<input type="checkbox"/> Your child's disability areas? (Check as many as apply)		
<input type="checkbox"/> Visual impairment <input type="checkbox"/> Developmental delay <input type="checkbox"/> Speech/language impairment <input type="checkbox"/> Emotional behavioral	<input type="checkbox"/> Hearing impairment <input type="checkbox"/> Traumatic brain injury <input type="checkbox"/> Orthopedic impairment <input type="checkbox"/> Other health impairment	<input type="checkbox"/> Specific learning disability <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Autism <input type="checkbox"/> Other:

Second child, if appropriate:

<input type="checkbox"/> Child's Name: _____		
<input type="checkbox"/> D.O.B. _____ Age: _____ (Must be under 19 to qualify)		
<input type="checkbox"/> Child's Diagnosis: _____ If you have not already sent in proof of your child's diagnosis or developmental delay, you MUST do so. This can be records from a medical facility or another service agency.		
<input type="checkbox"/> Your child's disability areas? (Check as many as apply)		
<input type="checkbox"/> Visual impairment <input type="checkbox"/> Developmental delay <input type="checkbox"/> Speech/language impairment <input type="checkbox"/> Emotional behavioral	<input type="checkbox"/> Hearing impairment <input type="checkbox"/> Traumatic brain injury <input type="checkbox"/> Orthopedic impairment <input type="checkbox"/> Other health impairment	<input type="checkbox"/> Specific learning disability <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Autism <input type="checkbox"/> Other:

Third child, if appropriate:

<input type="checkbox"/> Child's Name: _____		
<input type="checkbox"/> D.O.B. _____ Age: _____ (Must be under 19 to qualify)		
<input type="checkbox"/> Child's Diagnosis: _____ If you have not already sent in proof of your child's diagnosis or developmental delay, you MUST do so. This can be records from a medical facility or another service agency.		
<input type="checkbox"/> Your child's disability areas? (Check as many as apply)		
<input type="checkbox"/> Visual impairment <input type="checkbox"/> Developmental delay <input type="checkbox"/> Speech/language impairment <input type="checkbox"/> Emotional behavioral	<input type="checkbox"/> Hearing impairment <input type="checkbox"/> Traumatic brain injury <input type="checkbox"/> Orthopedic impairment <input type="checkbox"/> Other health impairment	<input type="checkbox"/> Specific learning disability <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Autism <input type="checkbox"/> Other:

The HEARTS Respite Program is required to conduct evaluations to make sure that the families we serve are benefiting from our program. We would like to ask you to complete the following questionnaire now and then again later as you leave the program. From this information, we can see how well our services have helped you and your family. Your identity will be kept confidential and no identifying information will be shared with anyone outside of this program. **IF YOU HAVE ALREADY COMPLETED THIS FORM IN THE PAST 3 MONTHS, DO NOT COMPLETE IT AGAIN.**

Perceived Stress Scale

Directions: The questions in this scale ask you about your feelings and thoughts during the last month. In each case, you will be asked to indicate by circling how often you felt or thought a certain way.

	Never	Almost Never	Some	Fairly Often	Very Often
1. In the last month, how often have you been upset because of something that happened unexpectedly?.....	1	2	3	4	5
2. In the last month, how often have you felt that you were unable to control the important things in your life?	1	2	3	4	5
3. In the last month, how often have you felt nervous and “stressed”?	1	2	3	4	5
4. In the last month, how often have you felt confident about your ability to handle your personal problems?	1	2	3	4	5
5. In the last month, how often have you felt that things were going your way?	1	2	3	4	5
6. In the last month, how often have you found that you could not cope with all the things that you had to do?	1	2	3	4	5
7. In the last month, how often have you been able to control irritations in your life?.....	1	2	3	4	5
8. In the last month, how often have you felt that you were on top of things?.....	1	2	3	4	5
9. In the last month, how often have you been angered because of things that were outside of your control?.....	1	2	3	4	5
10. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?	1	2	3	4	5

The PSS Scale is reprinted with permission of the American Sociological Association from Cohen, S., Kamarck, T., and Mermelstein, R. (1983). A global measure of perceived stress. *Journal of Health and Social Behavior*, 24, 386-396.

Cohen, S. and Williamson, G. Perceived Stress in a Probability Sample of the United States. Spacapan, S. and Oskamp, S. (Eds.) *The Social Psychology of Health*. Newbury Park, CA: Sage, 1988.

Please read and initial each line below:

- _____ I understand that I must return this form to complete the application process.
- _____ I understand that the information in this application packet will be kept confidential and will not be released to anyone outside of this program or the Children's Trust Fund Evaluation Team. I give permission for the Children's Trust Fund Evaluation Team to use the information in this packet and the information I provide later to evaluate the impact of this program on my family.
- _____ I understand that I must receive an approval packet **before I can begin** using Respite services.
- _____ I understand that Voucher Service Reports must be sent to HEARTS Respite before **the last day of each QUARTER.** (The report forms will be provided with the approval packet once eligibility is determined.) It will take up to 10 business days for checks to be mailed once the reports have been received in the HEARTS Respite office.
- Quarter 1 = August, September, October
 - Quarter 2 = November, December, January
 - Quarter 3 = February, March, April
 - Quarter 4 = May, June, July
- _____ I understand that it is my responsibility to select and train a trustworthy respite provider. Respite providers must be at least 18 years old and not reside in the home. United Cerebral Palsy or Children's Trust Fund will not be held responsible for any actions taken by the selected respite provider.

I agree to the above conditions and assure that funds will be used **ONLY** for respite care.

Signature: _____

Date: _____

Send completed application to: HEARTS Respite Program
1317 Overland Drive
Birmingham, AL 35216
Or FAX 205-979-6134

For questions, please contact Jeri Jackson in Birmingham at JBH50@aol.com or 205-823-9226.